Options for Collaborative Use of IFSP Prototype

Purpose: Some service providers may have forms they currently use that could be substituted for some pages of this prototype, as long as the bolded, italicized items are included in their customized IFSP. (The ***bolded***, ***italicized and Impact font*** items are the federal requirements for an IFSP.)

Format: Each page of this prototype is titled for the function it serves by the information covered within that page:

Referral, Intake, Data Collection
Family Information/Interview
Assessment
Plan
Participation
Review/Progress
Transition/Discharge/Exit

This prototype is meant to facilitate the IFSP process and to be used as a "living" document. The core ISFP would consist of Referral, Intake, and Data Collection; Family Information; Assessment; Plan, and Participation pages. These pages would be updated as needed. The Review/Progress and Transition/Discharge/Exit pages would be used accordingly.

Attachments: In addition to these prototype or substitution pages, some programs/services may have addendum pages to address their specific requirements.

Note: This prototype is provided as a model for an IFSP that meets federal requirements, as well as for data collection purposes. It is **NOT** intended to be all-inclusive or mandated for use. Any forms used locally for the purposes of *Early On*Ò must be on file at the Intermediate School District serving that area.

Referral, Intake, Data Collection Page ID #_____

Michigan Individualized Family Service Plan

Referral Source to *Early On:* _____Phone:_____Date:_____
CHILD'S LEGAL NAME:_____Current Residence:_____
Date of Birth:_____City of Birth:_____ SS#:_____ ☐ M ☐ F
Ethnic Heritage: ☐ Asian American ☐ Black or African American ☐ American Indian or Alaska Native
☐ Hispanic or Latino ☐ White ☐ Native Hawaiian or Pacific Islander
Child's present concerns and/or diagnosis:_____
School District of Residence:_____County:_____

☐ **PARENT** ☐ **GUARDIAN** ☐ **FAMILY MEMBER** ☐ **FOSTER PARENT**
Name:_____
Address:_____City:_____State:_____Zip:_____
Telephone: Day:_____Evening:_____Native Language/Mode of Communication:_____
Interpreter needed: ☐ Yes ☐ No Interpreter Provided: ☐ Yes ☐ No

☐ **PARENT** ☐ **GUARDIAN** ☐ **FAMILY MEMBER** ☐ **FOSTER PARENT**
Name:_____
Address:_____City:_____State:_____Zip:_____
Telephone: Day:_____Evening:_____Native Language/Mode of Communication:_____
Interpreter needed: ☐ Yes ☐ No Interpreter Provided: ☐ Yes ☐ No

PRIMARY HEALTH CARE PROVIDER:_____Telephone:_____
Address:_____

MEDICAL COVERAGE					**BENEFIT STATUS**				
	Yes	**No**	**Pending**	**Number**		**Yes**	**No**	**Pending**	**Number**
Medicaid	☐	☐	☐		SSI	☐	☐	☐	
CSHCS	☐	☐	☐		FSS	☐	☐	☐	
MI Child	☐	☐	☐						
Private (primary)	☐	☐	☐						
Private (secondary)	☐	☐	☐						

Other Family Members (Include name and relationship):	**Other Health Providers:**

Service Coordinator:_____Telephone:_____

SERVICES FAMILY CURRENTLY RECEIVES (CHECK ALL THAT APPLY)									
Education:	**Start Date**	**End Date**	**Rec?**	**Plan Used**	**Mental Health:**	**Start Date**	**End Date**	**Rec?**	**Plan Used**
Early On (Part C)			☐	☐	Family Support/DD Serv			☐	☐
Special Education (Part B)			☐	☐	Infant Mental Health/			☐	☐
Public Health:					Home Based Serv				
WIC			☐	☐	**FIA:**				
CSHCS			☐	☐	Employment Services			☐	☐
Infant Support Services			☐	☐	Emergency Funds			☐	☐
Immunizations			☐	☐	Public Assistance			☐	☐
Community Services/Other:					Child Care			☐	☐
Community Services/Other:					**Community Services/Other:**				

TYPE OF IFSP

☐ Interim IFSP/Date _____ ☐ Initial IFSP/Date _____
☐ ***6 Month Review/Date*** _____ ☐ ***Annual/Date*** _____
☐ Other Review Date _____ ☐ Other Review Date _____
Special circumstances that delayed IFSP > 45 days after referral:_____

Family Information/Interview Page ID#_____
Child's Name:_____BD:_____Date:_____

Family Information

If the family has given permission to an interview on the "Consent to Evaluation Form":

	Family Resources/Strengths	Family Concerns	Family Preferences
MEDICAL/HEALTH (Doctor, Insurance, Immunizations, Nutrition, Dental, Substance Use, Current Medications, Hearing, Vision, etc.)			
EDUCATION (Rehabilitation Services, Skill Development, School, Technical Training, College, etc.)			
MATERIAL NEEDS (Transportation, Housing, Utilities, Food, Clothing, etc.)			
EMPLOYMENT/FINANCIAL (Work, Income, Budgeting, etc.)			
LEGAL (Custody-Court Involvement, Legal-Aide, Child Support, Evictions, Civil Disputes, etc.)			
SAFETY (Physical Environment, Domestic Violence, Child Abuse/Neglect, Medical Issues and/or Mental Health Issues, etc.)			
SOCIAL/LEISURE/SPIRITUAL (Religious Organizations, Cultural, Recreational, Friends, etc.)			
PSYCHOLOGICAL/EMOTIONAL (Respite, Self Image, Family Relationships, Mental Health, Stress, etc.)			

Rank Family Concerns/Needs by placing a number next to each item in order of priority, in the Family Concerns column.

Assessment Page ID #_____
Child's Name:_____BD:_____Date:_____
Chronological Age:_____ Adjusted Age:_____

Child's Current Developmental Status

Informed clinical opinion to determine eligibility must be based on the integration of all 4 of the following sources of information. If eligibility was determined without any one or more of these sources, check appropriate box(es) and explain why that source was not used:_____

❑ Developmental History ❑ Health Status ❑ Observation of Parent and Child ❑ Developmental Evaluation

All parts of this table are required.

Area	Present Level of Development		Method/Tool – Person Completing (Name/Title)	Family's Priorities
	Date/Parent Input	Date/Professional Input		
Health ❑ see attached detail				
Hearing ❑ see attached detail				
Vision ❑ see attached detail				
Fine Motor ❑ see attached detail				
Gross Motor ❑ see attached detail				
Cognitive/ Thinking ❑ see attached detail				
Communi-cation ❑ see attached detail				
Social/ Emotional ❑ see attached detail				
Adaptive/ Self-Help ❑ see attached detail				

Evaluation Planning:
Where should it take place, and when?_____
If you could invite anyone, whom would you like to have present?_____
What would help you prepare for the evaluation?_____

Plan Page ID #_____
Child's Name:_____BD:_____Date:_____

Outcome # _____

GOAL/OUTCOME STATEMENT – What we would like to see happen for this child/family.

PRESENT STATUS – What is happening now?

WHAT ARE THE STEPS (objectives) to reach this outcome?

Expected Timeframe

Strategies/Methods for working on this outcome during this child and family's daily routines and activities. How will you know you have met the objective?

People who will be involved.

Explain how and why the child's outcome could not be met in the child's natural environment with supplementary supports, including options that have been explored.

Service Code	***Parent Initials***	***Frequency (How Often?) Intensity (How Long?)***	***Individual Or Group***	***Start Date***	***End Date***	***Location Code***	***Funding Code***

Other Services

To the extent appropriate, the IFSP must document services that are not required or covered under Part C. Listing the non-required services does not mean that those services must be provided, however, their identification can be helpful to both the family and the service coordinator to assist in securing those services, including those through public or private sources. These services must correspond to family identified outcomes.

Service	**Outcome #**	**Start Date Mo/Day/Yr**	**Duration (Months)**	**Provider Information**	***Fund Code***

Review/Progress Page ID #_____
Child's Name:_____BD:_____Date:_____

Review of the outcome/goal# _____must be conducted at least every six months **OR** more frequently if the family requests a review to determine the degree of progress toward achieving outcomes and whether modification or revision of the outcomes or services is necessary. The team will use the following scale to evaluate progress:
1 – Situation changes, outcome not needed 2 – Situation unchanged, still need outcome 3 – Outcome partially attained
4 – Outcome accomplished

Review Date:

Progress Summary	Team Eval	***Modifications/Revisions***

☐ I participated in the review of this outcome.

Parents Initials

Participation Page ID #_____
Child's Name:_____BD:_____Date:_____

IFSP Development Team and Contributors

IFSP meetings must include the parent(s), other family members as requested by the parent, an advocate or person outside the family as requested by the parent, the service coordinator, person(s) directly involved in conducting the evaluations and assessments, and as appropriate, persons who will be providing services to the child or family.

Printed Name and Role	Signature	Agency (if applicable)	Telephone

Parent Consent:

- ☐ I have signed an Authorization to Share Information with agencies.
- ☐ I helped write this plan. I understand and agree with its content. I agree to each of the services I have initialed.
- ☐ *Early On* has been explained to me, including my rights.
- ☐ I do not agree with this IFSP.

Parent Signature_____ Date_____

Service Coordinator Signature_____ Date_____

Plan will be next reviewed by _____(date). Review must be conducted at least every six months **OR** more frequently if the family requests a review.

Transition/Discharge/Exit Page ID #_____
Child's Name:_____BD:_____Date:_____

Transition Planning

The IFSP must include the steps to be taken to support the transition of the child into, within and from the Early On early intervention system. This section may be completed during a periodic review or evaluation of the IFSP, or at other times as appropriate. Transition activities include discussions with, and training of, parents regarding future placements, procedures to prepare the child, family and service providers for these changes. With parent consent, information about the child is shared with receiving providers to ensure continuity of services and assist in planning. **Transition needs should be expanded in an outcome within the IFSP to provide more specific details.**

What activity is needed?	Date Initiated	Who is Responsible?	Date Completed
Begin discussing transition process with family			
Review child's progress			
Identify current places and daily routine/activities			
Discuss options for child • special education • Head Start • therapy/consultation-private providers • early childhood programs • everyday community learning activities			
Visit possible settings/programs before a choice is made			
Decide on child's next setting/program			
Talk to child about transition			
Prepare a list of questions for the new staff			
Write down information about child that would be useful to the new staff			
Send specified information to new staff with parent's informed written consent			
Providers from new setting/program visit family			
Visit the new setting/program with child and meet the new staff			
Sign form authorizing disposition of child's Early On Ò records			
Attend meeting with staff from current and new settings/programs			
Child begins new setting/program			
Old staff maintains contact, as appropriate, with family after new activities begin			

Transition Date_____ Where transitioned to_____

*Method for Delivering Early Intervention Services**

Early Intervention Service Options	***Location***	***Funding Code***
16 - Assistive Technology	31 – Home	A. WIC
01 - Audiological Services	33 – Program for Typical Children	B. ISS
02 - Family Training, Counseling, Home Visit	34 – Service Provider Location (Out Patient)	C. Special Education
03 - Health Services	35 – Program for Children w/ Delays/Disabilities	D. Early On
04 - Medical Diagnostic Services	36 – Hospital (In Patient)	E. Private Insurance
05- Nursing Services	37 – Residential Facility	F. Medicaid
06 - Nutrition Services	38 – Other Setting _____	G. FIA
07 - Occupational Therapy		H. The Family
08 - Physical Therapy		I. CSHCS
09 - Psychological Services		J. CMH
10 – Service Coordination		K. MI Child
13 - Special Instruction		L. Other _____
12 - Social Work		
14 - Speech/Language		
11 - Transportation		
17 - Vision Services		
15 – Other EI Services _____		

*Early Intervention services must meet the developmental needs of the child and the needs of the family related to enhancing the child's development, and are based upon the Outcomes developed. Services are selected in collaboration with the parents and provided by qualified personnel in conformity with the IFSP. **Families initial each service to which they agree**.